

		FOR OHF USE					

LL 1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0038000</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Alden Town Manor Rehab & HCC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>60120 W. Ogden</u> <u>Cicero</u> <u>60605</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(773) 286-3883</u> Fax # <u>(773) 286-3743</u>		(Type or Print Name) <u>Steven M. Kroll</u>	
IDPA ID Number: <u>36-3695814</u>		(Title) <u>Chief Financial Officer</u>	
Date of Initial License for Current Owners: <u>09/16/92</u>		(Signed) _____ (Date) _____	
Type of Ownership:		Paid Preparer (Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Steven M. Kroll</u> Telephone Number: <u>(773) 286-3883</u>			

STATE OF ILLINOIS

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Facility Name & ID Number Alden Town Manor Rehab & HCC# 0038000 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>249</u>	Skilled (SNF)	<u>249</u>	<u>90,885</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>249</u>	TOTALS	<u>249</u>	<u>90,885</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,649</u>	<u>4,268</u>	<u>6,584</u>	<u>16,501</u>	8
9	SNF/PED					9
10	ICF	<u>40,800</u>	<u>10,132</u>	<u>558</u>	<u>51,490</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>46,449</u>	<u>14,400</u>	<u>7,142</u>	<u>67,991</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 74.81%

D. How many bed-hold days during this year were paid by Public Aid?

none (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)none

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 6/15/93

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 6/1/92 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 48 and days of care provided 5,673Medicare Intermediary AdminiStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Alden Town Manor Rehab & HCC

0038000

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	371,858	61,176		433,034	330	433,364		433,364		1
2	Food Purchase		507,742		507,742	(51,466)	456,276	(12,310)	443,966		2
3	Housekeeping	186,011	31,881		217,892	1,532	219,424		219,424		3
4	Laundry	70,778	21,957		92,735	586	93,321	(1,455)	91,866		4
5	Heat and Other Utilities			269,844	269,844		269,844		269,844		5
6	Maintenance	49,925		208,356	258,281		258,281	18,749	277,030		6
7	Other (specify):*										7
8	TOTAL General Services	678,572	622,756	478,200	1,779,528	(49,018)	1,730,510	4,984	1,735,494		8
	B. Health Care and Programs										
9	Medical Director			20,400	20,400		20,400		20,400		9
10	Nursing and Medical Records	2,515,115	192,503	5,928	2,713,546	4,356	2,717,902	(28,266)	2,689,636		10
10a	Therapy										10a
11	Activities	61,774	2,370	2,100	66,244		66,244		66,244		11
12	Social Services	32,890		(387)	32,503		32,503	387	32,890		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* Med Dir. Fellow.			45,006	45,006		45,006		45,006		15
16	TOTAL Health Care and Programs	2,609,779	194,873	73,047	2,877,699	4,356	2,882,055	(27,879)	2,854,176		16
	C. General Administration										
17	Administrative	204,289			204,289		204,289		204,289		17
18	Directors Fees										18
19	Professional Services			920,197	920,197		920,197	(808,969)	111,228		19
20	Dues, Fees, Subscriptions & Promotions			38,569	38,569		38,569	(24,042)	14,527		20
21	Clerical & General Office Expenses	601,693	18,795	34,164	654,652		654,652	66,088	720,740		21
22	Employee Benefits & Payroll Taxes			522,401	522,401	44,662	567,063	87,505	654,568		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,664	1,664		1,664	14,925	16,589		24
25	Other Admin. Staff Transportation			400	400		400		400		25
26	Insurance-Prop.Liab.Malpractice			126,579	126,579		126,579	1,672	128,251		26
27	Other (specify):*			317,693	317,693		317,693	(316,993)	700		27
28	TOTAL General Administration	805,982	18,795	1,961,667	2,786,444	44,662	2,831,106	(979,814)	1,851,292		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,094,333	836,424	2,512,914	7,443,671		7,443,671	(1,002,709)	6,440,962		29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Alden Town Manor Rehab & HCC #0038000 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			64,524	64,524		64,524	413,429	477,953			30
31	Amortization of Pre-Op. & Org.			9,356	9,356		9,356	33,029	42,385			31
32	Interest			159,377	159,377		159,377	911,782	1,071,159			32
33	Real Estate Taxes			18,750	18,750		18,750	739,255	758,005			33
34	Rent-Facility & Grounds			2,008,744	2,008,744		2,008,744	(2,007,984)	760			34
35	Rent-Equipment & Vehicles			8,736	8,736		8,736	28,343	37,079			35
36	Other (specify):*							61,897	61,897			36
37	TOTAL Ownership			2,269,487	2,269,487		2,269,487	179,751	2,449,238			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		246,638	829,774	1,076,412		1,076,412	(538,536)	537,876			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,327	136,327		136,327		136,327			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		246,638	966,101	1,212,739		1,212,739	(538,536)	674,203			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,094,333	1,083,062	5,748,502	10,925,897		10,925,897	(1,361,494)	9,564,403			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Alden Town Manor Rehab & HCC

0038000

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	13,751	30		9
10	Interest and Other Investment Income	(39,236)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,865)	2		13
14	Non-Care Related Interest	(62,094)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,079)	32		18
19	Entertainment				19
20	Contributions	(7,826)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(316,993)	27		24
25	Fund Raising, Advertising and Promotional	(11,743)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,052)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (435,137)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(644,278)		34
35	Other- Attach Schedule	(282,079)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (926,357)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,361,494)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS

Page 5A

Alden Town Manor Rehab & HCC

ID# 0038000

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Duane Morris prior year espense adjustment	\$ 2,598	19	1
2	American healtcare prior year exp. Adjustment	100	20	2
3	Town of Cicero prior year exp. Adjustment	13	20	3
4	Illinois healthcare association-back out pac fees	(896)	20	4
5	insurance expense adjustment (\$29 x # of beds)	(7,221)	26	5
6	back out part b c/allow's (non-cost) in gls 5212/3/4	(1,602)	39	6
7	hmo nurs supply c/a non-cost gl 5026	(20,286)	39	7
8	hmo nurs therapy c/a non-cost gl 5040	(213,683)	39	8
9	hmo nurs drugs c/a non-cost gl 5042	(43,306)	39	9
10	vending machine income	(1,942)	2	10
11	to correct ytd deprec exp to match detail	1,398	30	11
12	hmo nurs oxygen c/a non-cost gl 5080	(2,879)	39	12
13	laundry income-decrease laundry costs	(1,455)	4	13
14	back out prior year expense adj in gl 5206(soc.serv)	387	12	14
15	record expense on painting>\$1500 for '99	3,917	6	15
16	record expense on painting>\$1500 for '00	2,778	6	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(282,079)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Town Manor Rehab & HCC

0038000

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,807)	0	0	(7,503)	0	0	0	0	0	0	0	(12,310)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(1,455)	0	0	0	0	0	0	0	0	0	0	(1,455)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	6,695	0	12,093	0	0	0	(39)	0	0	0	0	18,749	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	433	0	12,093	(7,503)	0	0	(39)	0	0	0	0	4,984	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(27,090)	(1,176)	0	0	0	0	0	0	(28,266)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	387	0	0	0	0	0	0	0	0	0	0	387	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	387	0	0	(27,090)	(1,176)	0	0	0	0	0	0	(27,879)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	2,598	0	(811,567)	0	0	0	0	0	0	0	0	(808,969)	19
20	Fees, Subscriptions & Promotions	(24,404)	0	362	0	0	0	0	0	0	0	0	(24,042)	20
21	Clerical & General Office Expenses	0	4,121	35,004	19,345	7,618	0	0	0	0	0	0	66,088	21
22	Employee Benefits & Payroll Taxes	0	0	85,944	0	1,561	0	0	0	0	0	0	87,505	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	14,925	0	0	0	0	0	0	0	0	14,925	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(7,221)	8,893	0	0	0	0	0	0	0	0	0	1,672	26
27	Other (specify):*	(316,993)	0	0	0	0	0	0	0	0	0	0	(316,993)	27
28	TOTAL General Administration	(346,020)	13,014	(675,332)	19,345	9,179	0	0	0	0	0	0	(979,814)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(345,200)	13,014	(663,239)	(15,248)	8,003	0	(39)	0	0	0	0	(1,002,709)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Town Manor Rehab & HCC

0038000

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	15,149	384,514	11,855	0	1,911	0	0	0	0	0	0	413,429 30
31	Amortization of Pre-Op. & Org.	0	28,724	281	0	0	4,024	0	0	0	0	0	33,029 31
32	Interest	(105,409)	963,048	43,989	0	2,917	7,237	0	0	0	0	0	911,782 32
33	Real Estate Taxes	0	730,830	7,928	0	497	0	0	0	0	0	0	739,255 33
34	Rent-Facility & Grounds	0	(2,008,744)	760	0	0	0	0	0	0	0	0	(2,007,984) 34
35	Rent-Equipment & Vehicles	0	0	28,343	0	0	0	0	0	0	0	0	28,343 35
36	Other (specify):*	0	61,897	0	0	0	0	0	0	0	0	0	61,897 36
37	TOTAL Ownership	(90,260)	160,269	93,156	0	5,325	11,261	0	0	0	0	0	179,751 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	(281,756)	0	0	(24,518)	(58,195)	(174,067)	0	0	0	0	0	(538,536) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	(281,756)	0	0	(24,518)	(58,195)	(174,067)	0	0	0	0	0	(538,536) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(717,216)	173,283	(570,083)	(39,766)	(44,867)	(162,806)	(39)	0	0	0	0	(1,361,494) 45

Facility Name & ID Number Alden Town Manor Rehab & HCC

0038000

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rental Income	\$ 2,008,744	Cicero Associates Limited Partnership	100.00%	\$	\$ (2,008,744)
2	V	32 Interest Income	12,582	Cicero Associates Limited Partnership			(12,582)
3	V	33 Real estate taxes		Cicero Associates Limited Partnership		730,830	730,830
4	V	26 Insurance		Cicero Associates Limited Partnership		8,893	8,893
5	V	32 Interest - Mortgage		Cicero Associates Limited Partnership		801,724	801,724
6	V	32 Interest - loan		Cicero Associates Limited Partnership		173,906	173,906
7	V	36 Mortgage Ins. Prem.		Cicero Associates Limited Partnership		61,897	61,897
8	V	21 Misc.		Cicero Associates Limited Partnership		4,121	4,121
9	V	30 Depreciation		Cicero Associates Limited Partnership		384,514	384,514
10	V	31 Amortization		Cicero Associates Limited Partnership		28,724	28,724
11	V						
12	V						
13	V						
14	Total		\$ 2,021,326			\$ 2,194,609	\$ * 173,283

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Town Manor Rehab & HCC

0038000

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Benefits	\$	Alden Management Services, Inc.	0.00%	\$ 85,944	\$ 85,944	15
16	V	19 Management fees	824,719	Alden Management Services, Inc.		13,152	(811,567)	16
17	V	21 Gen'l & Admin.		Alden Management Services, Inc.		35,004	35,004	17
18	V	6 maintenance/utilities		Alden Management Services, Inc.		12,093	12,093	18
19	V	24 autos/seminars		Alden Management Services, Inc.		14,925	14,925	19
20	V	20 dues/subscriptions		Alden Management Services, Inc.		362	362	20
21	V	30 depreciation		Alden Management Services, Inc.		11,855	11,855	21
22	V	31 amortization		Alden Management Services, Inc.		281	281	22
23	V	33 real estate tax		Alden Management Services, Inc.		7,928	7,928	23
24	V	34 rent		Alden Management Services, Inc.		760	760	24
25	V	35 rent-equip/vehicles		Alden Management Services, Inc.		28,343	28,343	25
26	V	32 interest		Alden Management Services, Inc.		43,989	43,989	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 824,719			\$ 254,636	\$ * (570,083)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Town Manor Rehab & HCC

0038000

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	TUBE FEEDING	\$ 26,756	PYRAMID HEALTH CARE SERVICES	100.00%	\$ 19,253	\$ (7,503)	15
16	V	10	NURSING SUPPLIES	32,172	PYRAMID HEALTH CARE SERVICES		5,082	(27,090)	16
17	V	39	SUPPLIES/ PERDIEM FEES	59,800	PYRAMID HEALTH CARE SERVICES		35,282	(24,518)	17
18	V	21	GENERAL & ADMIN.		PYRAMID HEALTH CARE SERVICES		19,345	19,345	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 118,728			\$ 78,962	\$ * (39,766)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Town Manor Rehab & HCC

0038000

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 drugs	\$ 196,877	Forum Extended Care II	100.00%	\$ 154,268	\$ (42,609)
16	V	10 house stock	5,436	Forum Extended Care II		4,260	(1,176)
17	V	39 iv	72,017	Forum Extended Care II		56,431	(15,586)
18	V	22 fringe benefits		Forum Extended Care II		1,561	1,561
19	V	21 gen'l & admin		Forum Extended Care II		7,618	7,618
20	V	32 interest		Forum Extended Care II		2,917	2,917
21	V	33 real estate		Forum Extended Care II		497	497
22	V	30 depreciation		Forum Extended Care II		1,911	1,911
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 274,330			\$ 229,463	\$ * (44,867)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Town Manor Rehab & HCC

0038000

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 CPT revenues	\$ 457,143	Community Physical Therapy	100.00%	\$ 283,076	\$ (174,067)
16	V	31 Amortization		Community Physical Therapy		4,024	4,024
17	V	32 Interest		Community Physical Therapy		7,237	7,237
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 457,143			\$ 294,337	\$ * (162,806)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Town Manor Rehab & HCC

0038000

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	6 maintenance expense	\$ 6,293	Alden Bennett Construction	100.00%	\$ 6,254	\$ (39)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 6,293			\$ 6,254	\$ *	(39) 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Alden Town Manor Rehab & HCC # 0038000 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	Chief Executive		333,896	4.014	6.69	salary	\$ 23,929	21-1	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.		74,753	2.676	6.69	salary	5,357	21-1	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten		68,290	2.676	6.69	salary	4,894	21-1	3
4	Joan Carl d.	Secretary	Vice-President		168,886	4.014	6.69	salary	12,103	21-1	4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10	d. Joan Carl is the Secretary of Alden Management Services and all nursing facilities. She has an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12											12
13								TOTAL	\$ 46,283		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Town Manor Rehab & HCC # 0038000 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, Inc.
 Street Address 4200 W. Peterson
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773)286-3883
 Fax Number (773)286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	see page 8a...				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	Cambridge Healthcare		x	mortgage	\$73,492.00	8/1/97	\$ 10,617,600	\$ 10,307,803	7/31/32	7.7500	\$ 801,724	1							
2												2							
3												3							
4												4							
5	Corus		x	operating				735,000			93,203	5							
	Working Capital																		
6	Related Party - CPT	X		Operations	None					Varies	7,237	6							
7	Related Party - AMS/FECII	X		Operations	None					Varies	46,906	7							
8	wmf/huntoon		x	Operations	\$15,777.00	9/1/95	2,104,700	2,037,761		Varies	173,906	8							
9	TOTAL Facility Related				\$89,269.00		\$ 12,722,300	\$ 13,080,564			\$ 1,122,976	9							
	B. Non-Facility Related*																		
10	less: interest income										(51,817)	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (51,817)	14							
15	TOTALS (line 9+line14)						\$ 12,722,300	\$ 13,080,564			\$ 1,071,159	15							

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Town Manor Rehab & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038000

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-32-115-017-0000</u>	<u>Nursing home facility</u>	\$ <u>1,528.61</u>	\$ <u>1,528.61</u>
2. <u>16-32-115-018-0000</u>	<u>Nursing home facility</u>	\$ <u>1,528.61</u>	\$ <u>1,528.61</u>
3. <u>16-32-115-019-0000</u>	<u>Nursing home facility</u>	\$ <u>56,339.27</u>	\$ <u>56,339.27</u>
4. <u>16-32-115-020-0000</u>	<u>Nursing home facility</u>	\$ <u>78,621.21</u>	\$ <u>78,621.21</u>
5. <u>16-32-115-026-0000</u>	<u>Nursing home facility</u>	\$ <u>292,292.81</u>	\$ <u>292,292.81</u>
6. <u>16-32-116-020-0000</u>	<u>Nursing home facility</u>	\$ <u>131,279.65</u>	\$ <u>131,279.65</u>
7. <u>16-32-116-021-0000</u>	<u>Nursing home facility</u>	\$ <u>55,088.72</u>	\$ <u>55,088.72</u>
8. <u>16-32-116-022-0000</u>	<u>Nursing home facility</u>	\$ <u>55,572.42</u>	\$ <u>55,572.42</u>
9. <u>16-32-116-023-0000</u>	<u>Nursing home facility</u>	\$ <u>2,825.80</u>	\$ <u>2,825.80</u>
10. <u>16-32-116-024-0000</u>	<u>Nursing home facility</u>	\$ <u>2,752.97</u>	\$ <u>2,752.97</u>
	TOTALS	\$ <u><u>677,830.07</u></u>	\$ <u><u>677,830.07</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Town Manor Rehab & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038000

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-32-116-006-0000</u>	<u>Nursing facility parking lot</u>	\$ <u>1,293.58</u>	\$ <u>1,293.58</u>
2. <u>16-32-116-007-0000</u>	<u>Nursing facility parking lot</u>	\$ <u>930.26</u>	\$ <u>930.26</u>
3. <u>16-32-116-008-0000</u>	<u>Nursing facility parking lot</u>	\$ <u>1,829.93</u>	\$ <u>1,829.93</u>
4. <u>16-32-116-009-0000</u>	<u>Nursing facility parking lot</u>	\$ <u>2,640.06</u>	\$ <u>2,640.06</u>
5. <u>16-32-116-010-0000</u>	<u>Nursing facility parking lot</u>	\$ <u>2,451.13</u>	\$ <u>2,451.13</u>
6. <u>16-32-116-011-0000</u>	<u>Nursing facility parking lot</u>	\$ <u>1,769.00</u>	\$ <u>1,769.00</u>
7. _____	<u>Related Party - Alden Management</u>	\$ <u>118,551.00</u>	\$ <u>7,928.00</u>
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>129,464.96</u></u>	\$ <u><u>18,841.96</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A.
Square Feet:
94,195

B. General Construction Type:

Exterior
BRICK

Frame
STEEL

Number of Stories
3

C.
Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
Does the Operating Entity?

☐ (a) Own the Equipment
☒ (b) Rent equipment from a Related Organization.
☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing home	66,775	1991	\$ 1,137,260	1
2					2
3	TOTALS	66,775		\$ 1,137,260	3

Facility Name & ID Number Alden Town Manor Rehab & HCC

0038000

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	\$ 18,359	\$	22	\$	\$	\$ 18,359	4
5											5
6	249		1992	1992	9,104,204	289,022	30	303,473	14,451	2,028,190	6
7											7
8											8
	Improvement Type**										
9	Related Party-Forum:										9
10	Leasehold Improvement-Remodeling			1980	19,335		20			19,335	10
11	Leasehold Improvement-Remodeling			1980	1,208		10			1,208	11
12	Leasehold Improvement-Remodeling			1986	645		5			645	12
13	Leasehold Improvement-Remodeling			1990	404		5			404	13
14	Leasehold Improvement-Remodeling			1991	94		5			94	14
15	Leasehold Improvement-Remodeling			1993	8,304	830	10	830		7,474	15
16	Leasehold Improvement-Remodeling			1993	6,504	671	9.7	671		6,035	16
17	Leasehold Improvement-sign			1994	261	22	12	22		174	17
18	Leasehold Improvement-dryvit			1995	443	44	10	44		310	18
19	Leasehold Improvement-new ac			1999	723	48	15	48		145	19
20	Leasehold Improvement-roof			1985	972	51	19	51		870	20
21	Leasehold Improvement-roof			1994	863	58	15	58		460	21
22	Leasehold Improvement-roof			1997	819	55	15	55		273	22
23	Leasehold Improvement-roof			1998	1,390	93	15	93		371	23
24	Leasehold Improvement-parking lot asphalt			2000	111	11	10	11		22	24
25	Leasehold Improvement-hallway lighting			2001	155	16	10	16		16	25
26	Leasehold Improvement-DAL			2001	195	19	10	19		19	26
27											27
28	Related Party-AMS:										28
29	Leasehold Improvement-Remodeling			1993	4,266		7			4,266	29
30	Leasehold Improvement-Remodeling			1994	2,112	64	7	64		2,112	30
31											31
32	Related Party-FECII:			1999	7,804	414	5	414		598	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Alden Town Manor Rehab & HCC

0038000

Report Period Beginning:

01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Window glass repair	1992	\$ 1,600	\$ 160	10	\$ 160		\$ 1,507		37
38	CSI - boiler repair	1994	3,268		3			3,268		38
39	Tower cleaners - drapery	1995	1,557		5			1,557		39
40	Bartlett heating -pipe insulation	1995	3,700	247	15	247		1,562		40
41	CSI - a/c repair	1995	4,093	409	10	409		2,626		41
42	CSI - a/c repair	1995	4,027	403	10	403		2,584		42
43	CSI - pipe insulation	1995	1,981	132	15	132		880		43
44	CSI - chiller HVAC	1996	6,042	604	10	604		3,373		44
45	The floor source - carpet installation	1996	5,345	534	10	534		3,028		45
46	Ward door specialist, Inc. - metal door	1996	1,385	92	15	92		507		46
47	Shalom landscaping - planting	1996	8,000	800	10	800		4,933		47
48	The floor source - carpet installation	1996	6,049	605	10	605		3,226		48
49	Bartlett heating -pipe insulation	1996	18,526	1,236	15	1,236		7,823		49
50	Over charged by Bartlett	1996	(10,500)			(700)	(700)	(5,682)		50
51	Alden Bennett const. - heating, vent , a/c	1996	69,300	3,465	20	3,465		18,769		51
52	Alden Bennett construction - sanitary sewer lift station	1996	23,921	1,196	20	1,196		6,479		52
53	Arrigo enterprises, Inc. - heating and cooling sys. Cooridor	1996	10,931	546	20	546		3,005		53
54	Misco shawnee, Inc. - tile	1996	9,232	462	20	462		2,501		54
55	Misco shawnee, Inc. - tile	1996	9,020	451	20	451		2,443		55
56	General parts - repair dishwasher	1997	2,139	428	5	428		1,981		56
57	Svstem Electric - 120 volt circuit installed and replaced	1997	2,085	417	5	417		2,085		57
58	Climate - freon into a/c	1997	6,221	1,244	5	1,244		5,702		58
59	Long elevator - install new eyes on elevator door	1997	3,180	636	5	636		3,021		59
60	A&B cable - outlets installation	1997	11,520	2,304	5	2,304		9,600		60
61	Arrigo enterprises, Inc. - corridor renovation	1997	24,366	1,218	20	1,218		6,294		61
62	ABC - hvac repairs	1998	39,300	1,965	20	1,965		7,370		62
63	ABC - sanitary sewer lift station	1998	1,259	63	20	63		236		63
64	Coit drapery	1998	12,976	2,595	5	2,595		3,330		64
65	CSI - replaced fuse and cleaned ice machine	1998	3,267	327	10	327		1,144		65
66	Wigdahl-replace parking lot timeclock and fixtres	1998	3,703	370	10	370		1,265		66
67	CSI - replace diffusers, bower motor	1998	7,571	757	10	757		2,523		67
68	Kraft paper - extractor	1998	2,071	138	15	138		426		68
69	Kraft paper - extractor	1999	10,000	1,000	10	1,000		1,500		69
70	TOTAL (lines 4 thru 69)		\$ 9,486,306	\$ 316,222		\$ 329,973	\$ 13,751	\$ 2,202,246		70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,486,306	\$ 316,222		\$ 329,973	\$ 13,751	\$ 2,202,246	1
2	New horizons - phone system	1999	3,332	333	10	333		750	2
3	Advanced parts & services - replace boiler	1999	2,504	125	20	125		333	3
4	Chicago cooling corp - cleaned condensor	1999	1,483	148	10	148		395	4
5	Chicago cooling corp - serviced cond. Water pump	1999	2,230	446	5	446		1,078	5
6	DBS contracting - sprinkler system maint.	1999	1,726	115	15	115		259	6
7	Climater service - repair roooftop exhaust	1999	1,864	186	10	186		403	7
8	Systm electric - underground pipes, new wires	1999	6,998	350	20	350		729	8
9	ABC - excavation work	1999	2,541	257	10	257		600	9
10	Alden design	2000	9,940	994	10	994		1,408	10
11	ABC	2000	8,502	850	10	850		1,560	11
12	Fox valley fire & safety	2000	1,887	189	10	189		331	12
13	Switching sys. - replace ATS	2000	3,343	223	15	223		353	13
14	ABC reverse accruals	2000	(2,571)	(257)	10	(257)		(406)	14
15	Tower cleaner - clean & repair drapes & sheers	2000	3,190	1,063	3	1,063		1,506	15
16	Chicago backflow, Inc - replace backflow valves	2000	1,806	120	15	120		140	16
17	Alden Bennett Const - seal & stripe parking lot	2000	3,109	311	10	311		363	17
18									18
19	Alden Bennett Construction (wall coverings)	2001	15,529	1,294	10	1,294		1,294	19
20	Patten (service elevator)	2001	1,547	77	20	77		77	20
21	Patten (water pump)	2001	2,325	107	20	107		107	21
22	CSI coker services (speed reduction unit)	2001	3,779	315	10	315		315	22
23	DBS contracting - (lawn sprinkler system)	2001	2,121	71	15	71		71	23
24	Simplex time (fire alarm)	2001	3,675	163	15	163		163	24
25	Simplex time (fire pump)	2001	1,800	60	20	60		60	25
26	GT mech (boiler repairs)	2001	4,701	940	5	940		940	26
27	CSI coker services (kitchen steamer)	2001	3,037	557	5	557		557	27
28	CSI coker services (pump assembly motor)	2001	3,784	315	10	315		315	28
29	The Floor Source (new carpet + labor cost)	2001	13,180	2,636	5	2,636		2,636	29
30	Alden Bennett Construction (time and material billing)	2001	3,177	318	5	318		318	30
31	T&T Irrigation Inc (lawn sprinkler system repairs)	2001	2,120	35	15	35		35	31
32	Alden Bennett Construction (carpet material)	2001	6,636	664	10	664		664	32
33	Alden Bennett Construction (repair cabinets and tip in various areas)	2001	6,303	210	5	210		210	33
34	TOTAL (lines 1 thru 33)		\$ 9,611,904	\$ 329,437		\$ 343,188	\$ 13,751	\$ 2,219,811	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,133,767	\$ 117,062	\$ 117,062	\$	varies	\$ 1,002,375	71
72	Current Year Purchases	12,976	3,181	3,181		varies	3,181	72
73	Fully Depreciated Assets	80,821	759	759		varies	79,980	73
74								74
75	TOTALS	\$ 1,227,564	\$ 121,002	\$ 121,002	\$		\$ 1,085,536	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	various	van/bus	1998-2000	\$ 11,938	\$ 3,797	\$ 3,797	\$	3	\$ 6,200	76
77	various	bus	2001	49,826	9,965	9,965		5	9,965	77
78										78
79										79
80	TOTALS			\$ 61,764	\$ 13,762	\$ 13,762	\$		\$ 16,165	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 12,038,492	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 464,202	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 477,953	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,751	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,321,512	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party- cost gets backed out

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 8,736 Description: copy machine lease

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>various</u>	<u>various</u>	\$ <u>2,362</u>	\$ <u>28,343</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>2,362</u>	\$ <u>28,343</u>	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$

13. /2003 \$

14. /2004 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input checked="" type="checkbox"/> NO	IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
		HOURS PER AIDE _____	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

skilled nurses on-site

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$ 207,856		\$			\$ 207,856	1
2	Licensed Speech and Language Development Therapist	39-3	hrs	27,504					27,504	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs	255,816					255,816	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	pg 16a	# of prescrpts				99,701		99,701	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	pg 16a					(53,001)		(53,001)	13
14	TOTAL			\$ 491,176		\$	\$ 46,700		\$ 537,876	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 627,528	\$ 711,424	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 272,000)	2,450,262	2,450,262	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	129,481	171,936	6
7	Other Prepaid Expenses	2,213	2,213	7
8	Accounts Receivable (owners or related parties)		574,387	8
9	Other(specify): <u>escrows/replac.reserv.</u>		708,012	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,209,484	\$ 4,618,234	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,137,260	13
14	Buildings, at Historical Cost		9,104,204	14
15	Leasehold Improvements, at Historical Cost	917,981	917,981	15
16	Equipment, at Historical Cost	256,351	1,206,266	16
17	Accumulated Depreciation (book methods)	(393,027)	(4,063,423)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>financ.fee/net</u>)		1,071,170	22
23	Other(specify): <u>due from affiliates</u>	427,218	427,218	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,208,523	\$ 9,800,676	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,418,007	\$ 14,418,910	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 398,583	\$ 417,954	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	317,799	317,799	30
31	Accrued Taxes Payable (excluding real estate taxes)	47,244	47,244	31
32	Accrued Real Estate Taxes(Sch.IX-B)		698,000	32
33	Accrued Interest Payable	351,209	432,307	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>current portion-notes/mortg payable</u>	315,000	407,911	36
37	<u>accrued expenses/due to IDPA</u>	644,136	644,136	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,073,971	\$ 2,965,351	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,231,950	3,255,440	39
40	Mortgage Payable		10,229,163	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>resident funds/credits</u>	310,673	310,673	43
44	<u>due to affiliates/accrued rent</u>	2,649,309	2,649,309	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,191,932	\$ 16,444,585	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,265,903	\$ 19,409,936	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,847,896)	\$ (4,991,026)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,418,007	\$ 14,418,910	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,978,672)	1
2	Restatements (describe):		2
3	External auditor's adjustments made after 2000 cost		3
4	report was submitted. These adj's have no effect on costs		4
5	(bad debt expense-non-allowable, and medicare revenue).	(217,080)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,195,752)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	347,856	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 347,856	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,847,896)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1		Amount	
Revenue			
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,211,599	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,211,599	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	303,838	6
7	Oxygen	18,813	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 322,652	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,937	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	62,216	21
22	Laundry	1,455	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 66,608	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	39,236	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 39,236	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	prior year insurance exp adj	3,482	28
28a	prior year exp adj's - various	3,908	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,390	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,647,485	30

2		Amount	
Expenses			
A. Operating Expenses			
31	General Services	1,767,038	31
32	Health Care	2,872,238	32
33	General Administration	2,172,666	33
B. Capital Expense			
34	Ownership	2,269,487	34
C. Ancillary Expense			
35	Special Cost Centers	1,081,872	35
36	Provider Participation Fee	136,328	36
D. Other Expenses (specify):			
37	Does not tie due to related party on schdl. V.		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,299,629	40
41	Income before Income Taxes (line 30 minus line 40)**	347,856	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 347,856	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Alden Town Manor Rehab & HCC

0038000

Report Period Beginning: 01/01/2001

Ending:

12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	231	256	\$ 7,226	\$ 28.23	1
2	Assistant Director of Nursing	2,563	2,678	66,704	24.91	2
3	Registered Nurses	32,214	34,846	844,880	24.25	3
4	Licensed Practical Nurses	20,410	21,616	424,462	19.64	4
5	Nurse Aides & Orderlies	100,625	108,581	1,170,778	10.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,963	2,082	22,873	10.99	9
10	Activity Assistants	3,164	3,505	38,901	11.10	10
11	Social Service Workers	2,002	2,028	32,890	16.22	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,080	37,980	18.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	37,856	40,197	333,877	8.31	15
16	Dishwashers					16
17	Maintenance Workers	1,906	2,050	37,435	18.26	17
18	Housekeepers	21,001	21,995	186,011	8.46	18
19	Laundry	7,752	8,406	70,777	8.42	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,215	7,019	101,679	14.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,206	1,492	29,887	20.03	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Clinical Support	846	868	23,304	26.85	32
33	Other(specify) Personnel	1,872	2,080	38,402	18.46	33
34	TOTAL (lines 1 - 33)	243,810	261,779	\$ 3,468,066 *	\$ 13.25	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	monthly	65,406	9-2	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	5,928	10-2	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	41	2,100	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	41	\$ 73,434		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	N/A	\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Alden Town Manor Rehab & HCC

0038000

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount		Description		Amount	
R Agpasa	administrator	0	\$ 5,057	Workers' Compensation Insurance	\$	60,316		IDPH License Fee	\$		
various executives	executive mgmt	0	77,526	Unemployment Compensation Insurance		11,610		Advertising: Employee Recruitment		552	
D Dalicandro	administrator	0	58,476	FICA Taxes		299,609		Health Care Worker Background Check		931	
Deshaw	administrator	0	4,030	Employee Health Insurance		20,781		(Indicate # of checks performed <u>133</u>)			
Dipaolo	administrator	0	9,190	Employee Meals		51,466					
R Glantz(\$1529)/J Palazzo:4985	administrator	0	6,514	Illinois Municipal Retirement Fund (IMRF)*				Ill healthcare association		8,329	
Weber:\$4456/Wulf:\$39,040	administrator	0	43,496	Union Health & Welfare		90,742		Misc. fees & subscriptons		4,353	
TOTAL (agree to Schedule V, line 17, col. 1)				Dental/Life		1,259		related party-ams		362	
(List each licensed administrator separately.)				Pension / 401k match		27,160					
B. Administrative - Other				Employee relations		2,945					
				Payroll misc. costs / emp. Vaccinations		1,175		Less: Public Relations Expense	()
								Non-allowable advertising	()
				related party-ams		87,505		Yellow page advertising	()
				TOTAL (agree to Schedule V, line 22, col.8)	\$	654,568		TOTAL (agree to Sch. V, line 20, col. 8)	\$	14,527	
TOTAL (agree to Schedule V, line 17, col. 3)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee	Type		Amount	Description	Line #	Amount		Description		Amount	
Alden Management Services	Mngmt Fees	\$	824,719					Out-of-State Travel	\$		
Blackman Kallick	Acctg. Fees		5,900								
Mackelvie & Associates	Legal Fees		24,154					In-State Travel		1,664	
Ken Fisch	Legal Fees		39,500								
Barry Greenburg	Legal Fees		3,769								
Janet Herman	Legal Fees		2,231					Seminar Expense		0	
Chicago Legal Services	Legal Fees		4,741								
Duane Morris prior yr exp adj	Legal Fees		(2,598)								
US Gas & Energy	Utility consult		2,428								
Corus Bank	Bank Fees		9,750					related party-ams		14,925	
American United	401 K admin.		950					Entertainment Expense	()
Various Misc.	Misc. Prof fees		4,653					(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		TOTAL		16,589	
(If total legal fees exceed \$2500 attach copy of invoices.)											

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Boiler repair	12/94	\$ 3,268	3	\$	\$	\$	\$	\$	\$	\$	\$	\$
2	Painting	6/95	13,250	3									
3	Painting	8/95	678	3									
4	Painting	9/95	740	3									
5	Painting	11/95	1,779	3									
6	Painting	12/95	1,315	3									
7	Painting	1/96	2,669	3									
8	Painting	2/96	1,372	3									
9	Rewiring	2/96	2,276	5									
10	Painting	3/96	1,782	3									
11	Fan	3/96	2,012	15									
12	Painting	4/96	3,472	3									
13	See page 22a	1996	18,923	3-15	4,431	2,910	675	675	675	675	675	675	
14	See page 22a	1997	9,243	3	3,081	3,081	1,477	0					
15	See page 22a	1998	25,643	3	4,495	8,548	8,548	4,053	0				
16	See page 22a	1999	11,752	3		1,959	3,917	3,917	1,959	0			
17	See page 22a	2000	28,466	3			4,821	9,489	9,489	4,668	0		
18	See page 22a	2001	5,076	3				1,371	1,692	1,692	322	0	
19													
20	TOTALS		\$ 133,716		\$ 12,007	\$ 16,498	\$ 19,438	\$ 19,505	\$ 13,815	\$ 7,035	\$ 997	\$ 675	\$

Facility Name & ID Number Alden Town Manor Rehab & HCC

STATE OF ILLINOIS

0038000

Report Period Beginning: 01/01/2001

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Ending: 12/31/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. II Health Care Assoc \$8,329
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,305 Line 12-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 136,327
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 51,466 Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Number ALDEN NURSING CENTER-Town Manor # 0033800 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
				FY98	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1 Condenser repair	4/96	2,205	10	221	221	221	221	221	221	221	221	221
2 Painting	6/96	1,791	3	597	249							
3 Air conditioner repair	6/96	2,711	10	271	271	271	271	271	271	271	271	271
4 Air conditioner repair	7/96	2,740	15	183	183	183	183	183	183	183	183	183
5 Painting	7/96	3,445	3	1,148	575							
6 Painting	8/96	2,111	3	704	410							
7 Painting	9/96	1,988	3	663	441							
8 Painting	11/96	1,104	3	368	307							
9 Painting	12/96	828	3	276	253							
10 Total to pg 22, line 13		18,923		4,431	2,910	675	675	675	675	675	675	675
11 Repair cooler	2/97	1,646	3	549	549	45						
12 Repair boiler	4/97	3,052	3	1,017	1,017	255						
13 Repair leak	8/97	1,550	3	517	517	301						
14 Repair compressor	11/97	1,414	3	471	471	393						
15 Repair compressor	12/97	1,581	3	527	527	483						
16 Total to pg 22, line 14		9,243		3,081	3,081	1,477	0					
17 Replace pump motor	2/98	1,719	3	525	573	573	48	0	0			
18 Painting	3/98	5,083	3	1,412	1,694	1,694	283	0	0			
19 Replace belts on fans	4/98	2,348	3	587	783	783	195	0	0			
20 Painting	6/98	5,415	3	1,053	1,805	1,805	752	0	0			
21 Repair boiler	7/98	2,308	3	365	769	769	405	0	0			
22 Painting	10/98	5,564	3	464	1,855	1,855	1,390	0	0			
23 Painting	12/98	1,513	3	42	504	504	463	0	0			
24 Replace actuator	12/98	1,694	3	47	565	565	517	0	0			
25 Total to pg 22, line 15		25,643		4,495	8,548	8,548	4,053	0	0	0	0	0
26 painting>\$1,500 1999	7/99	11,752	3		1,959	3,917	3,917	1,959	0	0		
27 Total to pg 22, line 16		11,752			1,959	3,917	3,917	1,959	0	0	0	0
28 Climate Service Inc (repair HVAC)	1/00	1,703	3			568	568	568	0			
29 Climate Service Inc (repair HVAC)	1/00	1,970	3			657	657	657	0			
30 Capps Plumbing & Sewer (plumbin	5/00	2,718	3			604	906	906	302	0		
31 GT Mechanical (repair HVAC)	7/00	1,898	3			316	633	633	316	0		
32 Capps Plumbing & Sewer (plumbin	8/00	1,965	3			273	655	655	382	0		
33 Alden Bennett Construction (painti	9/00	8,378	3			931	2,793	2,793	1,862	0		
34 Alden Bennett Construction (painti	11/00	1,502	3			83	501	501	417	0		
35 painting>\$1,500 for 2000	7/00	8,333	3			1,389	2,778	2,778	1,389	0		
36 Total to pg 22, line 17		28,466				4,821	9,489	9,489	4,668	0	0	0
37 Alden Bennett(paint/wallcover)	11/00	(1,508)	3			(501)	(503)	(503)	-1			
38 Capps(booster system)	1/01	2,705	3			902	902	902	0			
39 Coker(boiler)	4/01	3,879	3			970	1,293	1,293	323	0		
40 Total to pg 22, line 18		5,076			0	0	1,371	1,692	1,692	322	0	0